

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**02-10**

2. STATE  
**Oregon**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**SEP 23 2002**

4. PROPOSED EFFECTIVE DATE  
**July 1, 2002**

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY \$ -0-  
b. FFY \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

*Oregon (02-10)  
approved: 12/24/02  
effective: 07/01/02*

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.16-A, Parts 1 through 16.

10. SUBJECT OF AMENDMENT:

This transmittal is being submitted to remove the interagency agreements and contracts from the Oregon State Plan.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Per Attachment 7.3A

12. SIGNATURE OF STATE AGENCY OFFICIAL:

*Lynn Read for Herish Crawford Bobby S Mink*

13. TYPED NAME: Herish Crawford Bobby Mink

14. TITLE: Administrator, OMAP Director, DHS

15. DATE SUBMITTED:  
**9-19-02**

16. RETURN TO:

Office of Medical Assistance Programs  
Department of Human Services  
500 Summer Street NE, 3<sup>rd</sup> Floor, E35  
Salem, OR 97301

ATTN: Carole Van Eck

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: **SEP 23 2002**

18. DATE APPROVED: **DEC 20 2002**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
**JUL - 1 2002**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: *Bunee Butterfield*

22. TITLE: *Associate Regional Administrator*

23. REMARKS:

**POSTMARKED:** *9/20* *Salem*  
(DATE) (DATE)



*Department of Human Resources*

AFS Contract #40014

SSD Contract #40510

**ADULT AND FAMILY SERVICES DIVISION**

PUBLIC SERVICE BUILDING, SALEM, OREGON 97310

JOINT PROGRAM BETWEEN THE  
OREGON COMMISSION FOR THE BLIND  
OREGON ADULT AND FAMILY SERVICES DIVISION (AFS)  
SENIOR SERVICES DIVISION (SSD)  
AND THE  
OREGON CHILDREN'S SERVICES DIVISION (CSD)

AN INTEGRATED ACTION PROGRAM FOR  
VOCATIONAL REHABILITATION OF  
PUBLIC ASSISTANCE RECIPIENTS  
WHO ARE DEFINED AS LEGALLY BLIND

DATE APPROVED 8/29/84	EFFECTIVE DATE 4/1/84	DATE TO CO.
TN # 84-16	SUPERSEDES 8-33	COMMENTS

**INTRODUCTION**

**A. Purpose:**

The Oregon Commission For The Blind, Adult and Family Services Division, Senior Services Division and Children's Services Division jointly concur that the fundamental purpose of this agreement is to delineate clearly roles and responsibilities in order to optimize services to the blind and to facilitate the rehabilitation of the public assistance recipient into gainful employment. The by-product of this effort would be the closure or reduction of the public assistance grants of those legally blind persons who have the potential for work contingent upon the provision of comprehensive social and rehabilitative services. The achievement of these goals is dependent upon a counselor, a case manager and assistance worker, working as a team in the planning and provision of social and rehabilitative services for their common clients.

**B. Mutual Objectives of OCB, AFS, SSD and CSD:**

1. Develop selection criteria and systematic methods of identifying those public assistance and service recipients who are legally blind and who may be suitable candidates for vocational rehabilitation.
2. Establish specific mechanisms through which the newly-dependent blind person may receive prompt rehabilitation services, thus expediting the early rehabilitation into employment.
3. Develop effective inter-agency procedures for coordinating agency services for the optimal vocational rehabilitation and well-being of blind and public assistance and service clients, in order that they may realize full or partial self-support.
4. Provide sufficient, prompt and high quality vocational rehabilitation, social and health services for persons accepted in the program as defined by this agreement.

I. Rehabilitation Goal

OCB will accept referrals from AFS, SSD and CSD and provide service to those blind public assistance recipients who have rehabilitation potential.

II. Clients to be Served

- A. Supplemental Security Income (SSI) recipients whose payment is based on disability due to blindness.
- B. Blind recipients of AFDC including a parent, a child or a child in AFDC Foster Care over age 17.
- C. Persons receiving services through SSD or CSD.

III. Criteria for Selection

The following variables should be jointly considered by OCB, AFS, SSD and/or CSD in screening public assistance and service recipients for OCB services.

- A. Special emphasis will be placed on serving new applicants and recipients.
- B. Factors which will be considered in determining rehabilitation eligibility include:
  - 1. Evidence of blindness which constitutes a handicap to employment.
  - 2. Reasonable expectation for employment.

IV. Referral Procedures

- A. The primary responsibility for referral to OCB of recipients of public assistance grants and services rests with AFS, SSD and CSD.
- B. After acceptance as a client by OCB on the basis of legal blindness, there shall be communication with respect to carrying out a rehabilitation plan including appropriate services which might be provided by AFS, SSD and/or CSD.
- C. AFS or SSD will have the primary responsibility for the referral to OCB of those public assistance recipients who are not receiving services from CSD. This responsibility pertains to all categories of assistance. The responsibility between AFS and SSD rests with the agency having responsibility for financial services.
- D. The following referral procedures will be observed by CSD, SSD and AFS. The Referral Form, DHR 224, will be completed by the agency staff person and will require available supporting information including social/medical/psychological data provided prior to the OCB counselor's signature of acceptance. Each agency will be given a copy according to the instructions printed on the referral form.
- E. OCB will be responsible for reporting to the referring agency the disposition of the referral at the time the OCB decision is made.

DATE APPROVED	8/29/84
EFFECTIVE DATE	4/1/84
DATE TO C.O.	
RESEDES	80-33
COMMENTS	